CIVIL SOCIETY FUND

Strengthening civil society for improved HIV&AIDS and OVC service delivery in Uganda

ANNUAL REPORT

1ST JULY 2011 TO 30TH JUNE 2012

Jointly prepared by CSF Management Agents: The Technical Management Agent, the Monitoring and Evaluation Agent, and the Financial Management Agent

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Cover Photo: A family that has benefited from CSF support

EXECUTIVE SUMMARY

Since its inception in 2007, the Civil Society Fund (CSF) has increasingly made greater strides in addressing the burdens posed by HIV/AIDS, and orphans and other vulnerable children (OVC) in Uganda. CSF is a unique funding mechanism whereby development partners pool resources to support the civil society organizations (CSOs) to institute a harmonized and coordinated response to these challenges. Currently the fund is contributed to by the United States Agency for International Development, the United Kingdom Department for International Development, Irish Aid, Danish International Development Agency, and Swedish International Development Cooperation Agency. Overall, CSF has boosted the national response by not only providing financial support to CSOs, but also helping them to overcome capacity gaps for increased efficiency in their programs; as well as strengthening their monitoring and evaluation (M&E) systems so as to obtain reliable data for decision making at all levels. The 5th year of the CSF mechanism marks the completion of its initial stage, in preparation for its transition into a more longer-term management structure; to continue pursuing the goal of ensuring that civil society provision of prevention, care, treatment and support services in HIV/AIDS and OVC are harmonized, streamlined, effective, and in support of national plans and policies.

CSF has realized several successes this year, topmost of which is expanding the access and utilization of quality HIV and OVC services to the communities served by its sub-grantees. This year CSF has contributed 8.96% to the national OVC target. CSF has also provided 66,946 HIV positive clients (8.58% of the national target) with at least one clinical service, ranging from clinical care and monitoring to social support services. CSF has met 5.84% of the national target for condoms distribution to targeted populations.

An important area of success for CSF this year is the building of capacities of its sub-grantees. The capacity building interventions made have yielded improvements in OVC and HIV programming, enabling 92% of sub-grantees to meet the minimum CSF quality standards, as compared to 85% in 2011. This success will be consolidated further as CSF continues to implement its recently developed decentralized capacity building models.

CSF has also strengthened financial systems and reduced fraud exposure. A total of UGX110m was recovered during the year from the nine forensic reviews and value for money audits conducted. Last year, a total of UGX 157m had been recovered.

CSF has systematically strengthened the data use from 23% in 2009 to 54% in 2010, 57% in 2011 and 71% in 2012. This has consequently improved programming through instituting more effective interventions and addressing gender gaps in programming; for instance, male uptake of HIV Counseling and Testing (HCT) services improved from 32% in 2010 to 50% in 2011; male uptake of HIV care services improved from 28% to 34% and couple uptake of HCT services improved from 6% in 2010, to 11% in 2011 and 15% in 2012. CSF further analyzed and used program data to inform proposal development and produced 7 abstracts that were accepted for presentation in international conferences.

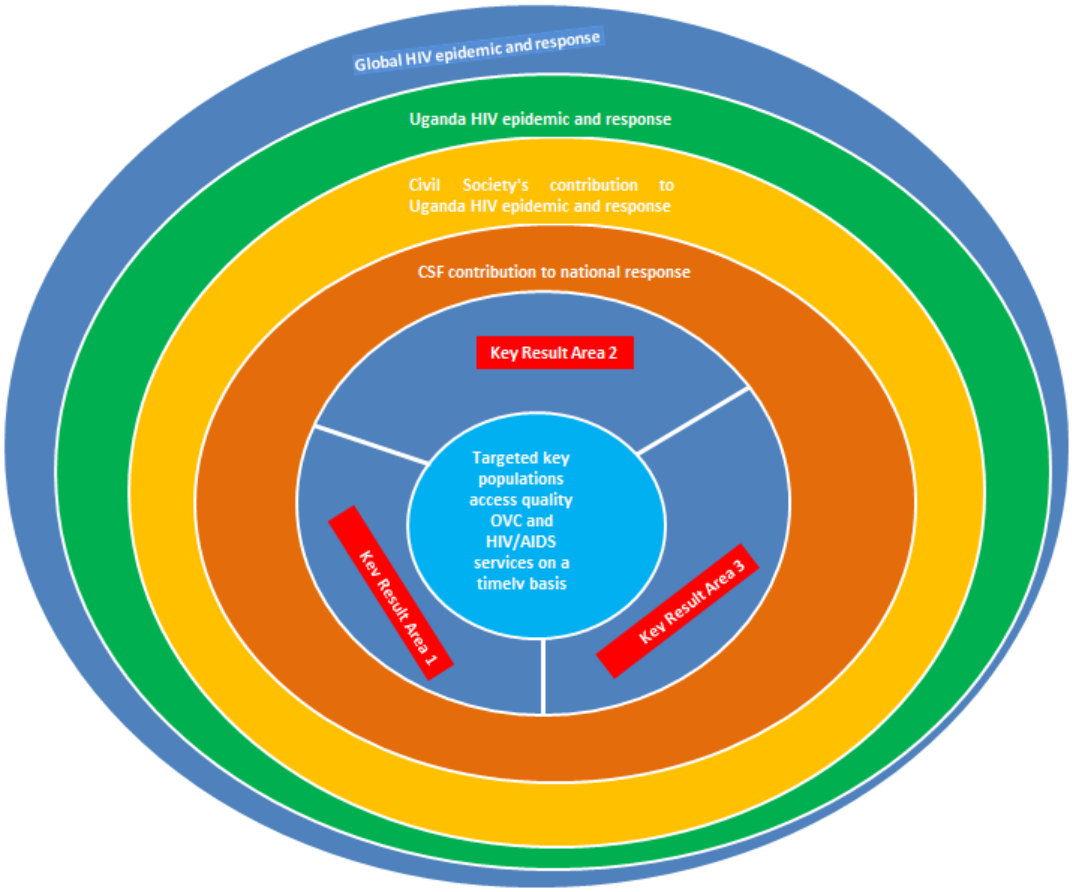
CHAPTER I: CIVIL SOCIETY FUND'S CONTRIBUTIONS TO THE NATIONAL RESPONSE

CSF contributed towards strengthening the national HIV & AIDS as well as OVC responses at all levels. CSF staff and some sub-grantees participated in review of the outgoing National Strategic HIV/AIDS strategic plan (NSP) and subsequent development of the revised NSP 2011/12 to 2014/15 and the National HIV prevention Strategy 2011-2015. These two major national documents are expected to reinvigorate and re-energize the country's effort s in the next five years and commitment to reverse the epidemic. CSF has also contributed to the national objective of building the capacity of the different players in civil society for delivery of quality HIV/ AIDS services by strengthening the capacity of 72 Civil Society Organizations to deliver quality HIV and OVC services in 107 districts.

This fiscal year, CSF provided 66,946 PLHIV (8.58% of all PLHIV in care in Uganda) with comprehensive HIV care treatment and support services which included: clinical monitoring and management of opportunistic infections; cotrimoxazole prophylaxis; TB screening and treatment; ART adherence counseling; SRH services; minimum package of prevention with positives; nutritional support; psycho-social support services offering general counseling, spiritual support, safe water vessels and insecticide treated mosquito nets; and home based care services. CSF provided services to 79,795 OVC which is about 8.95% of the national target; reached 825,160 people with HIV prevention messages; CSF contributed to the national HCT target of 80% of the population eligible for by testing and giving results to 479,209 people; conducted safe male circumcision of 4,137 men (0.41% of the national target) and distributed 10,582,726 condoms, which is about 5.84%of the estimated number of condoms that were required in the country during the year. These services were provided by a total of 81 sub-grantees working in 107 districts.

CSF further contributed towards strengthening the national OVC M&E system by sharing CSF OVC data collection tools with the national OVC technical working group for possible adaptation into the national OVC M&E framework as national OVC primary data collection tools.

Figure 1: CSF Service Delivery Framework



Legend

Key Result Area 1: CSF Management Strengthened
Key Result Area 2: Institutional and Technical Capacity of CSF Sub-grantees Strengthened
Key Result Area 3: Service Delivery in the NSP/NSPPI Program Priority Areas Increased

During the Year, CSF engaged in interventions to strengthen the institutional, technical and financial management capacity of all CSF sub-grantees to provide quality HIV and OVC services. Learning and knowledge management among sub-grantees and other strategic partners was also strengthened. The capacity building interventions were guided by the CSF capacity building plan and decentralized capacity building models. The CSF used approaches like onsite mentoring and coaching, blended learning (self-administered), experience sharing workshops, training workshops, compliance school (topical) articles and offsite technical support to strengthen sub-grantee capacity. Program assessments and documentation of the capacity building activities undertaken by CSF showed that there were significant improvements in institutional capacity and staff knowledge and skills due to the interventions implemented during the year. There will be an evaluation of the models and the findings of this will be used to realign CSF's capacity building activities to the new management structure.

The three capacity building models piloted by CSF:

- **Partnership for Accountability and Capacity Transformation (PACT) Model:** This model consists of three tracks: Track 1: Capacity building by CSF Management Agents; CSF used this track to directly support and supervise the lead agencies as well as the four regional technical assistance teams. Track 2: Sub-contractors; this track involved building capacity through selected sub-contractors. Track 3: CSF sub-grantees implemented their own capacity building activities using in-house approaches.

- **The Lead Agency Model:** This is where the larger and more experienced CSF funded sub-grantees (lead agencies) partner with smaller sub-grantees to build their capacity. Currently eight NNGOs have been selected as lead agencies.

- **Regional Technical Assistance Model**: Under this model, experts are identified from local governments, experienced NGOs as well as the private sector, and are organized into four regional technical assistance teams. These teams are tasked with the responsibility of identifying capacity gaps among CSF sub-grantees and building their capacity.

Strengthened gender sensitive programming among sub-grantees: Gender was identified as a common gap among sub-grantees in 2010. To address this, CSF developed a gender mainstreaming strategy, gender blended learning models, and trained all its sub-grantees in gender during the year. End-of-project assessments showed that 90% of all sub-grantees had integrated gender issues in their programs and were institutionalizing gender as opposed to addressing gender in a discretionary manner as had been noted previously. There was evidence that sub-grantees were proactively including issues of gender in their interventions to address gender-related obstacles in accessing services. All sub-grantees demonstrated that before program decisions are taken, an analysis is made of the likely outcomes for women and men, and boys and girls. This has influenced the selection of community resource persons to work with, and where there are glaring instances of limited involvement of one gender, affirmative action is done to address this gap. For example sub-

grantees were targeting men at popular socializing events for HIV prevention services. Because of these actions, current performance shows that about 50% of people attending HCT, BCC sessions and accessing OVC services are men. Deliberate efforts have been undertaken to popularize female condoms to increase women's influence on negotiating for safer sex. Program reviews showed that this was successful in many communities where this was undertaken and the popularity of the female condom had greatly increased.

Strengthened sub-grantees' capacity in strategic planning, grants management and proposal development:

The organizational capacity assessments conducted at the beginning of the year showed that only 25% of sub-grantees had up-to-date and appropriate strategic plans. Only 20% felt they had adequate skills in proposal writing and grants management. These were identified as major challenges to resource mobilization. By the end of the year 50% of sub-grantees had been supported to develop new strategic plans and improve their skills in proposal development and grants management. It is anticipated that these will result in improved capacity of these sub-grantees to mobilize for resources.

Taking organizations to another level

"A resource mobilization plan was developed and a focal person identified as a result of our training in resource mobilization. We believe this approach will increase resources for service delivery." YSA Dokolo

"We had no experience working with the high risk groups; the training and mentorship helped us to clarify many things. This exposure has enabled us review our strategies and targets we had planned in one of our projects. We are now more confident when dealing with these populations", Restless Development.

"We have now started the process of developing our new strategic plan that incorporates OVC to replace the one which expired. Our staff members have been assigned responsibilities in teams to develop the different sections of the strategic plan. This will enable them to understand and own the plan for successful implementation." Caritas Nebbi.

Sub-grantees and local government's capacity to conduct outcome assessments improved: during the year CSF supported the training of 188 staff from its sub-grantees and local government staff. These were able to successfully manage, provide quality assurance and conduct LQAS surveys in 10 districts. CSF intends to utilize this capacity to conduct more LQAS surveys in future.

Sub-grantees M&E capacity improved: CSF conducted various coaching and mentoring sessions and comprehensive M&E training for over 132 staff from 80 sub-grantees during the year. End-of-project reports have shown that the M&E capacity of sub-grantees has continued to improve greatly. By the end of the year, the proportion of sub-grantees utilizing data has increased from 54% seen in 2010 to 57% in 2011 and 72% in 2012. In addition three-day training in GIS was conducted for 35 sub-grantee staff to enable them utilize GIS techniques in data use for improved programming. Follow up has shown that use of GIS generated analysis has helped sub-grantees to analyze spatial trends, mapping populations and assessing performance of field staff. This information is being utilized by sub-grantees during their project reviews to make better program decisions. A website linking up sub-grantees was established by Straight Talk Foundation as a result of the training and it serves as a resource center for providing GIS information and sharing general base map layers among the trained users. It is envisaged that the continued use of GIS will further enhance sub-grantees data presentation and utilization.

Improved scope and quality of HIV and OVC services

During the year, CSF reviews showed that the quality of services delivered by sub-grantees had improved with 92% of sub-grantees meeting CSF minimum standards compared to 72% that was seen in FY 2009/10. Improvements were also noted in integration of sexual and reproductive health services as all sub-grantees were now aligned to national requirements of including SRH-related services in their HIV interventions compared to only 25% seen in FY 2009/10.

In April 2011, CSF brought together its sub-grantees, local government leadership and service providers, regional HIV/AIDS and OVC implementing partners as well as development partners in a regional experience sharing workshop to share information, experiences, achievements, lessons learnt and strategies for improving HIV and OVC programming in the respective regions. Evaluation of the regional experience sharing workshops showed that all participants valued the time spent at the workshop greatly. They noted that the practical experiential learning from their peers had enabled them gain more skills and knowledge in advocacy, documentation of project achievements, and better ways of addressing issues of sustainability at all stages of the project cycle, resource mobilization and practical ways of solving common M&E challenges. The bringing together of other non-CSF partners resulted in creation new partnerships and linkages.

CHAPTER II: SPECIAL SECTION

In this chapter, we provide independent analyses of key themes that cut across the Civil Society Fund management agents' scope. The themes were selected based on areas of special focus in the national dialogue around HIV/AIDS and OVC policy and service delivery, including topics of interest to CSF stakeholders. The following six themes are presented within this special section: Scaling up Global Best Practices; Innovating for Results; Innovating for Results; Advocacy and Networking; The Civil Society Fund and Aid Effectiveness; and Gender Mainstreaming and Integration.

SCALING UP GLOBAL BEST PRACTICES

The CSF management agents have supported the introduction and/or scaling up of a number of global best practices in the course of their work. These include best practices in service delivery as well as in capacity building and management.

a. Improved monitoring of the wellbeing of each individual vulnerable child using the adapted Child Status Index (CSI)

Under the stewardship of Ministry of Gender, Labor and Social Development, CSF partnered with the Transcultural Psychosocial Organization (TPO) to reinvigorate the use of the CSI tool to improve the monitoring of the wellbeing of each individual OVC on a quarterly basis. CSF through a participatory process adapted the CSI tool developed by MEASURE Evaluation to contextualize it to the Ugandan situation. This was done to make it more user friendly for community volunteers that lead the role of monitoring vulnerable children. During the first phase of rolling out the CSI tool, all CSF OVC sub-grantees were trained on the correct way of using tool. The second phase involved coaching the CSOs how to enter the collected data into a CSF designed database; analyze the data collected and generate simple CSO specific automated reports. In addition the CSOs were given technical assistance on how to make evidence-based decisions to improve their programs using information for the automated reports that they produce. The snowball effect of all this is CSF is able to use the aggregated data from its sub-grantees to influence the national OVC response. One such example is that during the development of the national OVC Vulnerability Index (VI); CSF played a pivotal role in guiding the development of the child-related questions that were included in the VI.

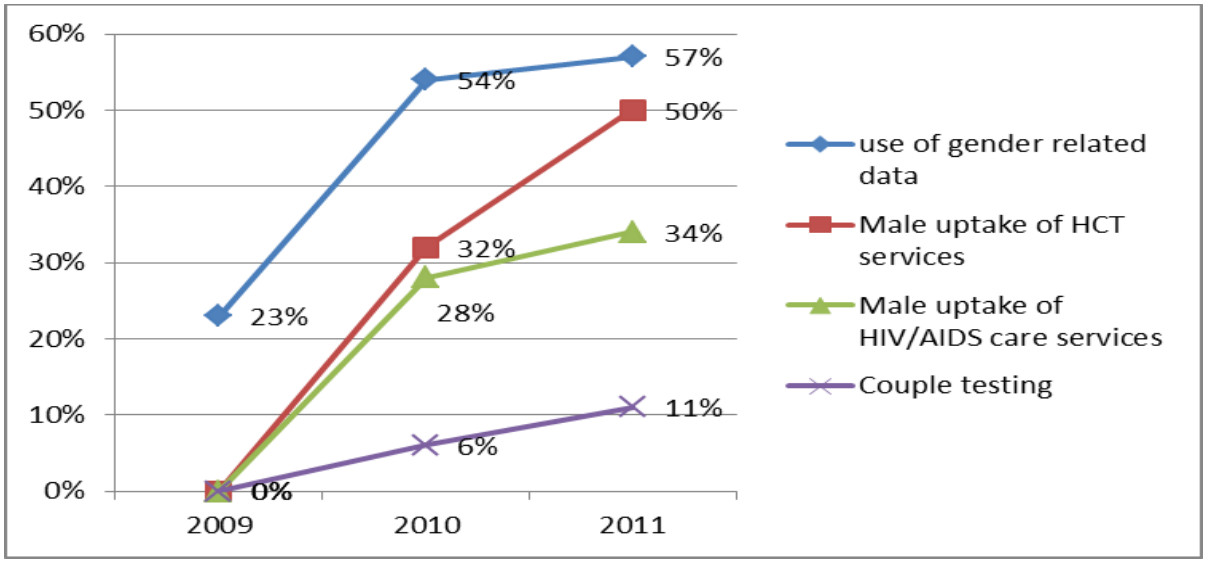
Figure 2: OVC who was supported by CSF sub-grantee FOCREV to learn metal works, and has started his own workshop

b. Strengthened capacity for data use at national, CSO, and local government levels – for programming and district plans.

CSF has systematically strengthened sub-grantees' capacity for data use over the years, from 23% in 2009 to 54% in 2010, 57% in 2011 and 71% in 2012. Sub-grantees used data to guide their decisions to refocus interventions; for instance data was used in designing of gender-sensitive interventions such as couple targeting, as well as special packages for hard-to-reach populations, for example, moonlight HCT and HCT camping.

CSF has utilized data to improve and focus the development of Requests for Applications (RFA); and to improve programming, which in turn has led to improved equity in service delivery. For instance, CSF noted gender gaps in service delivery; the data depicted low male turn up for HCT (32%) and HIV/AIDS care services (28%). After strengthening CSO capacity to use data, tremendous improvement was made towards bridging gender gaps as illustrated in the graph below:

Figure 3: Trends in use of gender related data and its effect on equity of services



At the international level, CSF used her program generated data to develop abstracts which will be presentation at the XIX International AIDS Conference in Washington D.C., U.S.A. in July 2012. The abstracts include: a) *Bridging Gender Gaps in Access to HIV/AIDS Services through Improved Data Use by Implementers;* b) *Harnessing SMS technology to Monitor and Scale up Access to Youth Friendly Services;* c) *Strengthening Civil Society Contribution to the National HIV/AIDS Response through a Harmonized and Coordinated Funding Mechanism;* and e) *Trends in People Testing for HIV Among Civil Society Organizations in Uganda: Implications for Expanding HIV testing.*

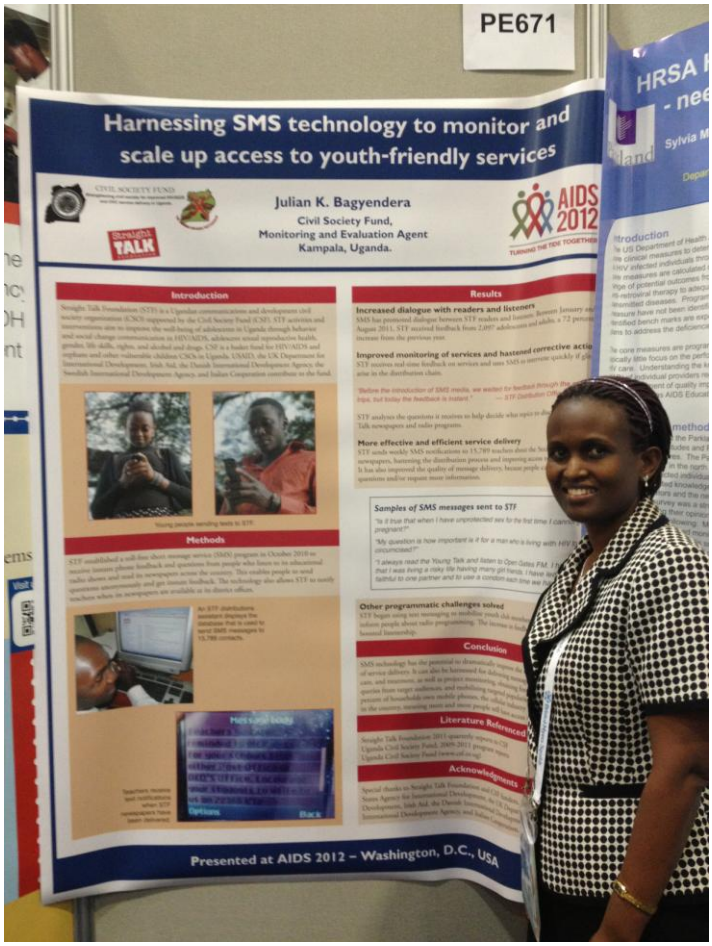


Figure 4: MEA Chief of Party, Julian Bagyendera, presenting a poster abstract at the XIX July 2012 AIDS Conference in Washington D.C.

Other CSF abstracts accepted for presentation at international conferences include: *Community Knowledge Levels About Tuberculosis In 10 Districts Of Uganda: Implications For The National TB Control Program* to be presented at the 43rd Union World Conference on Lung Health, to take place on 13-17 November 2012, in Kuala Lumpur, Malaysia. Additionally, *Bridging Gender Gaps in Access to HIV/AIDS Services through Improved Data Use by Implementers* will be presented at the International Conference on Gender Based Violence, in Nairobi, Kenya, in August 2012. Another abstract was accepted by the American Evaluation Association for presentation in Minneapolis, U.S.A. in October 2012, is entitled *Measuring Outcomes of HIV/AIDS and OVC Interventions using the CSF model.*

c. Strengthened strategic partnership through the development of the Combination HIV Prevention RFA

This year CSF issued a Request for Applications (RFA) titled *Reduction of New HIV Infections through Enhanced Community Engagement in Combination HIV Prevention.* It aims to empower individuals and communities to effectively demand for quality HIV/AIDS services; increase adoption of safer sexual practices; to create a sustainable enabling environment that mitigates the underlying socio-cultural, gender based and other structural drivers of the HIV epidemic; and to achieve a well-coordinated HIV prevention response. In line with the NSP, this RFA is based on combination HIV prevention approach where biomedical, behavioural and structural interventions are delivered simultaneously to an agreed scale and intensity and with clearly defined linkages and referrals.

In the course of developing the RFA, CSF collaborated with several partners, including the World Bank (WB), the United Nations Population Fund (UNFPA), the Joint United Nations Program on HIV/AIDS (UNAIDS) and technical staff from the targeted districts (Arua, Gulu;

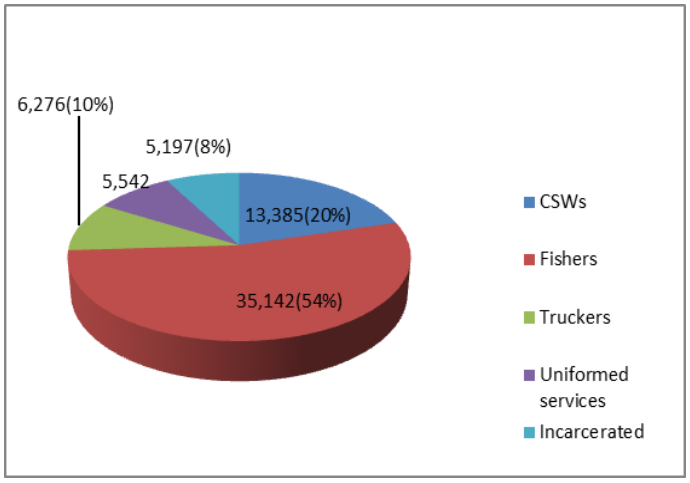
Kabale; Kasese; Mayuge and Rakai). It is anticipated that through this closer collaboration with the districts, from concept development to implementation, CSF should be able to achieve a better coordinated response in the focus districts; address structural drivers of HIV in their correct context as well as promote accountability by individuals, community and duty bearers. The emphasis on structural drivers and community engagement, which were previously not adequately programmed for is also expected to yield more sustainable behavioral changes.

As part of the partnership, during the implementation of this RFA, the World Bank will spearhead an impact evaluation which will enable the partners to quantify the impact of combination HIV prevention in Uganda. This will be the first ever initiative to determine the impact of HIV combination prevention approach in the world. The findings will guide HIV combination prevention programming in the country and beyond.

d. Increased focus on key populations rather than general population for the effective delivery of HIV/AIDS prevention, care and treatment services.

CSF has focused her strategies on key population that constitute key drivers of the HIV epidemic, in line with the revised National Prevention Strategy (NPS) 2011-2015. The Uganda HIV Prevention Response and Modes of Transmission Analysis AIDS Indicator Survey (UAIS) 2011 further reported that 10% of all new HIV infections are from commercial sex workers (CSWs). CSF reached a total of 122,209 (48.16% female) key populations including fisher folk, migrant workers, the disabled, CSWs, and truckers through innovative ways. This involved multicomponent approaches that included strategies such as community dialogue sessions, peer education, individual and group counseling, group discussions/support groups, hotlines, and provision of HIV prevention related materials (for example, brochures and condoms). While radio spots and outside broadcasting were often an essential element of these campaigns. Entertainment education (EE) an approach that integrates health information for behavior change into community events that are above all entertaining with a local context storyline was also used.

Figure 5: Categories of MARPS that were reached with HIV prevention interventions



Prevention messages that use mass media reach large audiences and engage them through memorable plots and appealing characters. EE weaves health information into a short-term storyline within a local context. All these evidence based interventions were designed to ensure that they change high-risk behaviors rather than simply raising awareness about HIV and AIDS. They aimed at delaying initiation of sex, reducing the number of sexual partners, increasing the use of

condoms and increasing uptake of safe male circumcision and HIV counseling and testing services.

Figure 6: Drama performance by CSF sub-grantee SCIPHA during an HIV/AIDS outreach in Kabarole

Condom promotion was linked to all community based and health facility based HIV prevention interventions. This year a total of 10,582,726 condoms were distributed with a focus on locations where key populations live. Of the condoms distributed, 11.79% were female condoms. Program assessments carried out in the year showed that the demand has been created for female condoms in these communities and that 78% of the persons in targeted communities had access to a condom when they last needed it. The CSF end-of-project assessments this year has also shown that increased education and distribution of condoms has led to an increase in condom use among these targeted populations. The CSF 2011 LQAS study conducted in 10 districts showed that 72.8% of individuals who had sex with non-marital partner and used a condom in last 12 months compared to 56% seen in a national survey conducted in 2006. Although this is a high figure, it is not universal as desired so CSF will continue to educate the public on the importance of using condoms in during high risk sexual encounters.

e. Integrating HIV into OVC interventions

In order to ensure supported OVC and their households receive comprehensive care, CSF has supported sub-grantees to integrate HIV services in the OVC programs. This integration also ensures that the long-term health impacts of HIV/AIDS on OVC are addressed. Program reviews conducted during the year showed that 62% of sub-grantees had integrated HIV services in their programs. The key entry points have been inclusion of HIV prevention messages and HCT for the supported households. This is because OVC are more vulnerable to abuse and exploitation, and are also more likely to engage in unsafe behaviors, increasing the risk of HIV infection. Other interventions provided strengthening the referrals between affected children and HIV care centers. Some of the OVC identified as positive are counseled to address any issues of children's rights and to offer psychosocial support so they are better prepared emotionally to handle the illness and deal with issues of stigma. CSF ensured all sub-grantees update directories and include providers of HIV services in their network of referral partners. This is because evidence shows that successful integration of HIV and OVC services requires a strong referral and monitoring system.

f. One-stop mobile center for a continuum of prevention and care

CSF sub-grantees involved in delivering HIV prevention and care have identified cost efficient mechanisms in service delivery. Health workers, counselors and Village Health teams (VHTs) come together to provide services to beneficiaries previously mobilized by VHTs. At an agreed site that is usually a community health center, the team provides integrated services in sexual reproductive health (SRH), prevention of mother-to-child transmission of HIV/AIDS (PMTCT) and HIV/AIDS education, sexually transmitted infections (STI) screening and treatment, dispensing family planning (FP) methods including condoms and oral contraceptives, HIV testing and counseling and CD4 testing. This enables beneficiaries to access multiple services in terms of information, tests and commodities in one center. This arrangement enables health workers to deliver multiple services and understand their patients better. The beneficiaries' waiting time is reduced and they spend less on transport costs as there is no need for return trips to get other services. Only beneficiaries that need referrals need to come back to the health facility or go to a bigger health facility for further care and treatment services.

g. Utilization of post-test clubs as change agents

Post-test clubs are peer support coping mechanisms that are formed voluntarily by individuals or couples after testing for HIV and getting results in CSF sub-grantee programs that undertake HCT. Club members may be HIV positive or negative. Post-test club members have been effectively used as change agents that motivate new community members to go for HCT and associated services. Club members that test HIV-positive provide live testimonies to illustrate how they have come to terms with HIV infection and explain their coping mechanism plans that support their survival.

h. HCT for couples to promote harmonious relationships

HCT provides an opportunity for couples to co-exist positively no matter the result of their HIV tests. The counseling provided not only focuses on understanding the basics of HIV infection and prevention, but also on defusing possible conflict situations arising from the test results before they can happen. Couples whether discordant or concordant, then make joint plans to co-exist by avoiding harmful practices such as gender based violence, alcohol abuse or engaging in unprotected sex. Couples are also encouraged to make wills to avert possible injustices usually meted out to the female spouse in case the husband dies first.

i. Intensified health education to increase demand for condoms

Condoms provide an effective barrier against the transmission of STIs including HIV. CSF sub-grantees have reported a high demand for both female and male condoms among targeted beneficiaries following intensified health education on this form of HIV prevention.

j. Use of Geographic Information System (GIS) to plot spatial coverage of services

CSF has utilized the Geographic Information System (GIS) to expand the scope of data analysis and reporting. Thematic maps depicting spatial coverage of the different interventions were shared with stakeholders and they have assisted sub-grantees during proposal development, determining geographical coverage where there low or no coverage avoiding overlaps and duplication of services. The maps have guided the CSF in development of RFAs targeting the underserved areas. Maps have also been produced for the MOH quality improvement unit to share with partners implementing related projects in the MOH arranged quality improvement workshop.

k. Strengthened measurement of outcomes of CSF interventions

While previously CSF largely generated volumes of output data, this year we made deliberate efforts to strengthen measurement of program outcomes using the LQAS, CSI and End of project assessments.

CSF 2012 LQAS

CSF conducted the LQAS survey in January and February 2012, in partnership with seven national non-governmental organizations (NNGO) who are CSF sub-grantees, 10 local governments and STAR-E LQAS project. LQAS is a population-based survey technique that aggregates results in order to extrapolate performance for larger areas such as district, regions, and the entire country. The LQAS survey covered 10 districts namely; Adjumani, Koboko, Hoima, Masindi, Buliisa, Mubende, Mukono, Rakai, Bukedea and Kaberamaido.

Findings that are to be addressed in line with findings from other national studies include; low comprehensive knowledge on HIV prevention (29%) and how mother-to-child transmission occurs (9%); and low comprehensive knowledge particularly among the youth on correct steps for condom use (5%). On average, 33% OVC aged 5-17 years reported experiencing cases of child abuse and 46% of OVC households are food secure. Preliminary LQAS findings were disseminated to the districts and they came up with plan of action to address low performing indicators.

End of project assessments
In February 2012, CSF conducted end of project assessments (EPA) for 41 OVC projects that closed at the end of March 2012 and these reflected an improvement in the wellbeing of children and their caregivers across all the CPAs. For instance, it was reported that there was an increase in the number of meals from one to two or more in supported households, and a several OVC were facilitated by CSF to startup businesses through skills training and provision of relevant startup kits, in activities such as motorcycle repairs, metal fabrication, hair dressing and tailoring.

Over the past four years, a total of 98,795 OVC (49.7 females) were served, making about 11% contribution to the national target. It was also noted that interventions led to increased school attendance and retention.

CSF also conducted end of project assessments for 29 HIV1 and 8 NNGO projects that closed at the end of March and June 2012 respectively. The preliminary findings from the assessments have noted that most projects achieved set targets but there are identified gaps in the sustainability of the projects. The assessment findings have been provided to the sub-grantees and for NNGOs, they are informing the development of cost extension proposals.

k. Sustainability of OVC interventions

CSF has endeavored to foster the sustainability of OVC interventions beyond the funding it provides. To ensure sustainability issues are addressed, CSF requires sub-grantees to institutionalize sustainability right from proposal development stage throughout the project cycle. Some of the strategies being employed to achieve this include training of sub-grantees on project sustainability; strengthening of community structures; strengthening of partnerships between the sub-grantees and local government; support to sustainable interventions including vocational and apprenticeship training, village savings and loan associations, support in starting income generating activities, and promoting linkages between sub-grantees and government development initiatives like NAADS and NUSAF.

l. Other best practices

Other best practices implemented by CSF sub-grantees included: moonlight HCT, use of religious leaders to mobilize couples to access services, integration of services particularly on HCT outreaches for more comprehensive service delivery and promoting faithfulness among married people, by adapting the *Faithful House* model developed by Catholic Relief Services, which is based on Christian principles of loyalty and respect for one's spouse.

INNOVATING FOR RESULTS

This section presents innovative strategies implemented by CSF strengthen sub-grantee capacity to deliver quality services.

Innovating CSO-level capacity strengthening interventions

CSF promotes cost effective learning through blended learning modules
One of the biggest challenges that CSF faced in its capacity building programs was the cost and time of conducting training for the numerous sub-grantee staff and volunteers across the country. In order to address this, CSF came up with an idea of using blended learning modules that can enable several learners at sub-grantee sites to learn new skills and knowledge in their places of work at their own pace and at a marginal cost. Initially CSF piloted the first two blended learning modules and evaluated this approach. Results of the evaluation showed that this approach was feasible and that it improved the knowledge of sub-grantee staff who participated. Subsequently, one more module on gender was developed and another on communications will be developed next year. Owing to the success and potential of this approach, Makerere University, the premier university in Uganda has requested CSF for permission to utilize the gender module as a training aide for all university students in its new program of training all its students in gender. The CSF will continue to expand and implement this approach in the coming year.

CSF implements capacity building interventions through public - private partnerships
CSF recognizes that in the current fast-paced and complex era, it is almost impossible to do anything alone. CSF developed the *Regional Technical Assistance (RTA)* model where it selected a private management consultancy firm to manage this model and bring in competencies from the private sector. Together with this firm, CSF was able to identify 32 specialists in HIV, OVC, gender, communications, M&E, management and organizational development of whom seven were from the local governments, 15 from CSOs and 10 from the private sector to form four regional technical assistance teams. During the year these teams supported CSF to strengthen the capacity of 22 sub-grantees. This collaboration has proved to be fruitful to the CSF sub-grantees and to the public and private sector staff involved in that the sub-grantees have received more regular and closer mentorship whereas the public sector staff have better appreciated the role of CSOs in service delivery– as evidenced by the testimony below:

One of the public sector workers (a district planner) involved had this to say about the arrangement, "*There is enriched perspective arising from this model arrangement. The benefit of this collaboration is direct; when you help others your capacity is also built. Now when I am giving support on planning for OVC to my district colleagues, I give informed advice. I can now point out to the district where we are failing to support CSOs yet they are providing most of the critical OVC services in the district. The model gives us a very good linkage.*"

Improved OVC service delivery through integration of Child Protection and Psychosocial Support into other Core Program Areas

As a result of training received in the integration of child protection and psychosocial support (CP/PSS), CSF sub-grantees are offering more comprehensive services to their clients. OVC end of project assessments established that 91% of all OVC served receive CP and PSS in addition to other services. Integrating CP and PSS into all CPAs has promoted efficiency because sub-grantees are now implementing a wholesome package that promotes optimal utilisation of resources. Integration has minimised vertical programming and in effect the OVC are receiving a more meaningful package of services much more economically. Integration of CP and PSS also leads to value addition and sustainability of services. From the synergy that comes with implementation of each CPA, PSS and CP will remain part of the services provided to the OVC even way after the project has phased out.

GENDER MAINSTREAMING AND INTEGRATION

This year CSF developed a Gender Strategy to guide the mainstreaming of gender into its programs and institutions. This is in line with Uganda's national strategy documents (National Strategic Plan and the National Strategic Program Plan of Interventions) which highlight gender issues as drivers of HIV/AIDS transmission and opportunities for expanded and improved prevention, care, and support services for vulnerable populations.

In order to increase the overall effectiveness and impact of CSF's interventions, programming for gender has been articulated as a priority in key CSF program documents. Recognizing that OVC and HIV/AIDS interventions impact females and males differently, CSF aims to ensure that the needs of both are brought on board during the design, implementation, monitoring and evaluation of its projects.

To further augment its efforts of mainstreaming gender, this year CSF trained 79 staff from 41 OVC sub-grantees. CSF also developed a training manual and adapted into a blended learning format, for use by sub-grantees. This continuum of interventions should increase efficacy while providing equal opportunities for both genders.

These blended learning modules are being rolled out for use by sub-grantees and other stakeholders, for instance, the School of Gender and Women Studies at Makerere University has expressed interest in utilizing this module to offer it as a university-wide course.

CSF further plans to revise the governance manual and strategic plan to strengthen gender components and will conduct gender audits at both governance and management level with the view of addressing the gaps.

THE CIVIL SOCIETY FUND AND AID EFFECTIVENESS

Uganda is one of the 57 partner countries that endorsed the Paris Declaration (PD) on aid effectiveness in 2005 and the follow on Accra Agenda for Action in 2008. This section highlights the contribution of the CSF mechanism to improving aid effectiveness in Uganda by assessing the mechanism and outcomes against the five key principles of the Paris declaration, namely: Ownership, Alignment, Harmonisation, Management for Development Results, and Mutual Accountability.

Ownership and Alignment: CSF is guided by a strategic plan that is guided by the National Development Plan. At the top of the structure of the CSF mechanism is the Steering Committee which is part of the board of the Uganda AIDS Commission, the overall coordinator of the HIV response in Uganda. This has ensured that projects implemented through this mechanism are coordinated and consistent with national development strategies. At sub-grantee level CSF ensures all interventions are aligned to the national documents. The approach of bringing together multiple donors to put resources in one basket managed through one project implementation unit has reduced the need for each donor to have a separate project management unit (PMU); reduced ties to aid; and ensured that aid to HIV and OVC CSOs is more predictable in keeping with the principles of the PD.

Harmonisation: By pooling aid in support of the national strategy, the CSF mechanism has contributed to making sure that there is harmonization of donor support to the CSO response to HIV and OVC in Uganda to the maximum extent possible. This is because the mechanism has enabled donors coordinate their support to civil society better amongst themselves hence avoiding duplication and the associated high transaction costs. This is in keeping with the PD commitment by donors to coordinate themselves better at the country level, reducing the large numbers of duplicative field PMUs. A review of the management structure this year showed that the CSF mechanism had enhanced linkage between GoU, donors, and CSOs. It has also increased contributions/revenue for CSOs in Uganda over time.

Managing for results: The CSF structure has a transparent and monitorable performance assessment framework. The CSF performance framework ensures that the mechanism delivers services to the intended beneficiaries in a cost effective way by tracking of unit costs for all services and making certain these are within the costs expected of programs of this kind in the country. A detailed review of the mechanism showed that because of this unique approach of partnership between donors, government and CSOs, the structure has turned CSF into an action-oriented organization with more focus placed on customer satisfaction.

Table 1: CSF Unit Costs per Service Provided

Intervention	Average unit Cost of CSF programs (UGX/person reached with the service)	Range seen with other similar national programs
BC messages	7,000 /person reached	Data not available
HCT*	11,000/person tested	10,000-18,500
Condoms (excluding cost of the condom)	150/piece distributed	25 – 3,000
HIV care (Non ART)	108,000 /person/year	88,000 to 240,000
OVC	110,000/OVC/year	67,000-300,000

**Excludes the cost for test kits for most implementers as sub-grantees get HIV testing kits from districts and only procure buffer stocks*

Mutual accountability: Since its inception the CSF mechanism has been reviewed three times by an arrangement that ensures that both donor and Ugandan stakeholders' responsibilities are assessed. CSF generates quarterly and annual reports shared and approved by all donors. This has contributed to ensuring that both the donors and Uganda account more transparently to each other for their use of these funds, and to their citizens in keeping with the PD.

The CSF mechanism has showed that rather than fragmented multiple donor projects and the associated costly fragmentation of aid, it is possible to have deepened engagement of CSOs; deliver results; become more accountable and transparent; change aid conditionality; promote national ownership of donor programs; and increase predictability of aid flow to CSOs.

ADVOCACY AND NETWORKING

Advocacy and networking play a pivotal role in supporting the national HIV/AIDS and OVC responses. To this effect, CSF has made great strides in mainstreaming advocacy interventions throughout each of its three Key Results Areas.

CSF developed a video documentary entitled *Fountain of Hope* and a success stories video entitled *Changed Lives,* which highlight the role and achievements of CSF. The videos will serve as powerful advocacy and fund raising tools. They have been disseminated to key stakeholders to further promote sharing of CSF success and best practices. Similarly, CSF uses other communications products such as flyers and brochures to advocate for CSF sub-grantees' successes in various thematic areas that can be replicated and scaled up. Whenever a new RFA is issued, CSF uses geographic information system (GIS) maps to identify underserved areas and advocate for appropriate services and funds to be allocated there. CSF has developed a variety of blended learning training tools that present multiple opportunities to advocate for emerging issues during the capacity building sessions conducted. One exciting instance to highlight the aforesaid is the prospects of Department of Women and Gender Studies at Makerere University using the CSF Gender Blended Learning Module to expedite the plan of mainstreaming gender in all its academic programs.

CSF has supported the strengthening of the capacity of the sub-grantees to advocate for key emerging issues, many of which are gender related, through the variety of methods. The routine ones include the joint supportive and/or targeted supervision. During each annual experience sharing workshop CSF innovates a key session where the sub-grantees can demonstrate their advocacy skills for emerging OVC and HIV/AIDS issues. In the last financial year, mock "community dialogues" were held where the sub-grantees were given the opportunity to engage in and advocate for relevant social issues that needed to be changed. This year the sub-grantees had a mock session with district local councils to advocate for added value of CSF funding and support. This proved to be a useful exercise in developing persuasive public speaking skills which are critical for advocacy in Uganda that happens to be a largely oral society. This approach was participatory; it encouraged the sub-grantees to come up with their own workable solutions and to be accountable.

In as far as service delivery is concerned; sub-grantees are required to demonstrate strong community advocacy interventions relevant to the services they are delivering. This will help increase the uptake of many facility based interventions. In addition the sub-grantees help to address any emerging behavioral and structural issues that may hinder the correct and consistent use of the advice within a given community. At national level CSF has specifically funded Uganda Network of AIDS Service Organizations (UNASO), National Forum of People Living with HIV/AIDS Network in Uganda (NAFOPHANU) and Uganda Network on Law, Ethics and HIV/AIDS (UGANET).

(UGANET) consortium to provide a platform for coordination, networking resource mobilization and information sharing among the three networks so as to improve on the effectiveness, efficiency and quality of their contribution to the national response to the HIV and AIDS epidemic. One of the aims of funding the consortium is to enhance the capacity of the district level networks so that they can effectively coordinate the activities of the members at that level. So far 20 district networks are being supported using CSF funding.

CHAPTER III: CHALLENGES AND LESSONS LEARNED

Challenges

Comprehensive HIV & AIDS knowledge is still very low; CSF LQAS 2012 stated that over 70% of the population have low comprehensive knowledge and still believe in myths such as mosquitos transmitting HIV. The UAIS also had similar findings on low comprehensive knowledge. Knowledge on correct steps for condom use is similarly very low; particularly among the youth (14%). CSF will develop a minimum content package for BCC messages to ensure that more information is provided on these low performance areas.

Referrals to other service providers continue to be constrained by limited points of referral for services such as CD4 testing, and other required OVC services. Service providers are also overwhelmed by big numbers of OVC, some of whom are turned away. To address this, CSF is working closely with other implementing partners to improve the referral system. In order to address issues of limited access to CD4 testing services, CSF allowed sub-grantees to support transportation of samples to sites with these services as a short term measure. The Ministry of Health is in the process of procuring CD4 testing machines, which should hopefully increase access to this service nationally in the long term.

There was inadequate supplies of commodities like condoms, HIV kits and anti-tuberculosis drugs due to failures in the national drugs logistics system. Some of the sub-grantees were able to utilize funds from other partners to procure drugs and other commodities to cover the shortfalls, but unfortunately some TB patients had to miss their drugs. To address this recurrent challenge, CSF plans to further strengthen collaboration between sub-grantees, districts and MOH to ensure sub-grantee needs are adequately catered for during planning. CSF will also allow some sub-grantees to procure buffer stocks for some allowed commodities in exceptional instances.

Limited range of expertise in some regions of the country hampered perfect implementation of the RTA model as planned. While care was taken to ensure that well-resourced and experienced professionals were selected for the RTA model, it was not possible to get a team of eight coaches per region with expertise in all the fields of HIV, OVC, OD, gender and M&E. This has mostly affected the north east and eastern teams. To address this, CSF intends to allow for more flexibility within the teams to allow some coaches to do more work and travel to regions that were previously not in their catchment area.

Lessons learnt

The use of 'Mama Clubs' where pregnant women and new mothers living with HIV are formed into clubs that sensitize other women on myths about PMTCT has proved to be a good strategy of increasing uptake of HCT, PMTCT, FP and early infant diagnosis (EID). These clubs also act as psychosocial support clubs to new mothers enrolled into PMTCT. 'Mama Clubs' formed were able to mobilize 82 HIV-positive mothers to access PMTCT in health centers in one week in an area that previously had a very low turn up for these services.

The use of one-stop service centers by CSOs for HIV prevention services where BCC messages are given, condoms are distributed, and HCT, CD4 testing, PMTCT including EID and mother-baby pair follow ups are conducted is feasible, facilitates comprehensive access to services, minimizes loss to follow up, and saves patients from trekking long distances to access each of these services. This can be achieved through collaboration between CSOs and health centers. Interviews conducted at one such site showed high levels of satisfaction by the beneficiaries. They noted that this arrangement had saved them a lot of costs that would have otherwise been spent on transport fares in order to access all these services.
Client exit interviews have shown that many stable PLHIV who have been in care for over three years are no longer interested in the mandatory routine counseling sessions as they have attended several such sessions and they reported that they do not usually learn new things or get in these sessions; they mainly come to the clinics to collect drugs and address emerging health needs. It is, therefore, important that HIV care programs factor this reality

Figure 7: KA-SCIPHA Mama's Club in Bukomero sub-county, Kiboga District

into their clinic procedures. Sub-grantees providing HIV care to consider this issue in their triage process in order to offer each client the appropriate attention and consider longer drug refill periods for such clients. This will improve client satisfaction, reduce staff workload and reduce waiting time.

Village Savings and Loans Associations (VSLA) methodology is proving to be a sustainable strategy for economic empowerment because of its long term benefits such as increased household investment that has consequently improved child nutrition, health and basic care. End-of-project assessments showed this to be one of the most successful OVC

interventions. Some of the formed groups were generating enough income that sub-grantees were considering weaning some of the households off their programs. In addition, some of these groups initially formed to support vulnerable households had now become registered and were able to access more government development programs that required registered groups.

CHAPTER IV: LOOKING FORWARD

CSF is undergoing the review of its management structure to determine a more sustainable structure to carry on the work started by the three management agents, whose contracts are ending. The review will spell out the form, technical competencies and resources required to carry forward the great work that the three management agents have done.

CSF will revise the governance manual as well as the strategic plan in line with the CSF management structure review recommendations. CSF will then revise the communication strategy and the capacity building strategy to fit to the structure as well.

Strengthening gender programming will continue to be important on the agenda of CSF. Gender audits will be conducted at both governance and management level with a view to addressing the gaps.

Special studies that were designed in the previous year will be conducted and results disseminate to improve both CSF and national programs.

The piloted program components such as capacity building models and the CSI will be evaluated to assess their value and make recommendations appropriately. The findings will similarly be disseminated for wider application beyond CSF.

In order to further increase access to essential services, three RFAs targeting NGOs and CBOs will be issued in the coming year. Baselines will be conducted for all new RFA to determine the starting point, after which LQAS will be used to measure the outcomes of CSF interventions.

-- Annexes --

ANNEX 1: SELECTED SUCCESS STORIES

Vulnerable family given a lifeline

Susan stands next to her grandmother at home. The goat she is holding by the rope produced all her other six goats

Susan (middle) with her grandmother and two of her cousins

**Names have been altered for confidentiality*

Susan* lost her mother in 1999 when she was only two years old. Her father separated from her mother before she was born, so Susan's grandmother, Dora, started looking after her and three of her cousins, who had also been orphaned. The family lives in Otuboi sub-county, Kaberamaido District (Eastern Uganda) in a one-room grass-thatched mud-and-wattle structure, which serves as a kitchen, storage, and bedroom.

By the time Susan was four years old, she began falling sick frequently. She lost weight and was extremely weak. It was then that a Community Resource Person visited the family and advised Grandma Dora to take Susan for an HIV test. The test revealed that Susan was HIV positive and her immune system had become very weak. She was immediately started on anti-retroviral therapy.

In 2008, when Susan was 11 years old, Civil Society Fund (CSF) sub-grantee Feed The Children Uganda (FTCU) started a program targeting youth between the ages of 10 and 24 years old living with HIV/AIDS in Susan's home parish, to support them and their families to start income generating activities. The CSF is funded by the United States Agency for International Development, UK Department for International Development, Irish Aid, Danish International Development Agency and Swedish International Development Cooperation Agency. CSF currently funds 80 civil society organizations in Uganda to provide harmonized and streamlined orphans and other vulnerable children (OVC) and HIV/AIDS services that are aligned with national plans and policies.

Susan was among the 10 children selected by FTCU in her parish, which is one of the 14 parishes covered by FTCU. She was given UGX50,000 ($19) to start an income generating project with the help of her grandmother. They opted for a goat rearing project, and used the initial capital to buy one goat. The goat has since given birth three times and produced six additional goats.

When Susan fell sick in 2010 and was admitted to the hospital, her grandmother was able to sell one of the goats to pay for her hospital costs. That same year, FTCU gave Susan another UGX50,000, which they spent on food and milk for the family, improving Susan's diet and boosting her immunity system. The next time Susan received money from FTCU, she decided to buy two chicken. Their eggs would not only provide a better diet for Susan and her family, but could also be sold in the local market and provide additional income for the family. In addition to the three grants mentioned above, FTCU also pays for Susan's schooling, which she is eager to attend now that she is strong and healthier. The organisation also gives her cousins scholastic materials.

Susan and her grandmother are grateful for the support they have been given, and they are already planning to expand their income generating activities by using some of their savings to buy a cow and sell milk. CSF has to date supported 90,674 OVC with a range of protection, care and support services.

CSF supports Islamic University in Uganda to implement HIV policy

IUIU students participate in an HCT outreach facilitated by AMICAALL at the university.

AMICAALL peer educators at IUIU after receiving IEC materials. The green and black gown is the peer educators' uniform.

The Islamic University in Uganda (IUIU) is integrating HIV/AIDS in academic programs and other activities in line with a policy launched in 2009 with the aim of preventing the spread of the virus among members of the university community. The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL), a sub-grantee of the Civil Society Fund (CSF), supported the university to develop a workplace policy on HIV/AIDS. A task force to address HIV issues at the university has also been formed. As a result, all departments are incorporating HIV/AIDS issues in their syllabi and arrangements have been made for peer educators to talk to worshippers at the mosque after prayers every Friday.

IUIU is one of the three universities where AMICAALL is implementing an HIV prevention project with support from CSF. The other two universities are Kyambogo University and Mbarara University of Science and Technology. CSF is a basket fund for civil society organizations contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency, and Swedish International Development Cooperation Agency.

Administrators at IUIU were previously opposed to discussion of most HIV prevention interventions other than abstinence and being faithful. University policies prohibited discussion of condom use and social interactions between male and female students and staff. In addition, HIV prevention information and services were also censored.

In July 2008, IUIU administration allowed AMICAALL to start carrying out HIV prevention activities at the university. This was the outcome of several consultative and sensitization meetings between AMICAALL and the university administration. Since then, AMICAALL has reached out to the university community through peer-to-peer education, dissemination of information, education and communication (IEC) materials, regular sensitization campaigns through drama, and voluntary counseling and testing (VCT) outreaches. Messages disseminated focus on abstinence until marriage; faithfulness among married partners; and correct and consistent use of condoms.

AMICAALL has had such a great impact on IUIU that today, the university administration allocates resources to support peer educators trained by AMICAALL to reach out to more students with HIV prevention services. The university also mainstreams HIV/AIDS in most of its calendar programs and celebrations. For instance, during the Ramadan (fasting) period in 2011, a number of HIV prevention activities like sensitization dialogues and VCT outreaches were carried out. The number of students utilizing VCT services also increased from 50 per quarter in 2008 to 300 in 2011.

Between July 2010 and December 2011, AMICAALL reached 1,858 members of the university community with messages on HIV/AIDS through peer educators. On the whole, since its inception, CSF has reached 2,572,118 individuals with HIV prevention messages through peer counselors and small group discussions.

Community gets HCT services for the first time

A pupil at Lokopio Primary School gets tested during the event

A health worker gives reproductive health education to Ombachi residents

Community Empowerment for Rural Development (CEFORD) has taken HIV prevention campaigns to previously unreached areas in Yumbe district.

On August 12, 2011 the residents of Ombachi parish in Romogi sub-county were delighted to access HIV counseling and testing (HCT) services right in their village, during an outreach conducted by CEFORD at Lokopio Primary School. Previously, the residents had to travel at least 10 kilometers to the nearest health facility for HCT.

CEFORD implemented the activity with funds received from the Civil Society Fund (CSF). CSF is a basket fund for civil society organizations contributed to by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency, and Swedish International Development Cooperation Agency.

CEFORD mobilized members of 29 households for the activity. The outreach team, which comprised staff from the district hospital, was overwhelmed by the big number of children, youth, and adults who waited eagerly to be attended to. Two hundred people were tested that day, including 28 caregivers and 109 orphans and vulnerable children (OVC). The activity was carried out as part of integration of HIV prevention into OVC interventions.

The team provided integrated services ranging from HCT, sexual and reproductive health, and nutrition education. They assessed the immunization status of children to check for adherence to immunization schedules. They also assessed the nutrition status of children and guided the caregivers on proper feeding.

The District Health Educator, Ms. Prisca Anyonga, who was also the team leader, was grateful to CEFORD and CSF for the initiative. "The clients felt highly regarded and expressed gratitude to CEFORD and the health providers for making this service accessible to them," she said.

Ms. Anyonga asked CEFORD to organize similar activities in other underserved communities.

Since July 2007, CSF has provided counseling and testing services to a total of 564,861 people who now know their sero-status and were given skills on either remaining HIV negative or living positively.

OCBO strengthens community parenting to protect children against HIV

Lutaaya Kizito, Stella's teacher who helped her return to school

Stella's caretaker

*Name changed for confidentiality

Orphans Community Based Organization (OCBO) has revived community parenting to protect young people in Rakai District against HIV/AIDS. OCBO promotes the involvement of community members to guide youth and help them avoid transactional and cross-generational sex, and the risk of contracting HIV/AIDS.

OCBO is supported by the Civil Society Fund (CSF) and aims to reduce the spread of HIV among young people between ages 10-24 in five sub-counties of Rakai District. CSF is funded by the United States Agency for International Development, United Kingdom Department for International Development, Irish Aid, Danish International Development Agency and the Swedish International Development Cooperation Agency.

OCBO supports people in target areas to form community based youth protection committees (YPC) and trains community resource persons in counseling and guidance. The organization also sensitizes community leaders on their roles in addressing HIV issues, especially among young people.

One of the beneficiaries is 14-year-old Stella* who was rescued from a forced marriage by community members and helped to return to school. Stella was a primary six pupil at Mityebiri Primary School when her father gave her away in marriage to a 28-year-old man living at Luteete village in Kasasa sub-county in January 2012. When one YPC member learnt of it, she alerted the school authorities, the sub-county Community Development Officer and OCBO staff. Together they rescued Stella while the police arrested her father. Stella was entrusted to the care of a female community member who worked with teachers to facilitate her return to school.

Between April 2008 and March 2012, OCBO enabled 8,576 youth to access HIV prevention services through video showings, discussion sessions after sports events, condom demonstrations, dialogue meetings with community members and testimonies of people living with HIV. Such interventions have led to positive behavior change among the youth in the target sub-counties. A case in point is the elimination of teenage pregnancy among beneficiaries of OCBO's apprenticeship program from eight in 2009 to zero in 2011.

Since 2007, CSF has provided 98,795 orphans and other vulnerable children (OVC), 50.2% of whom are female, with services that include food security, socio-economic assistance, care and support, child protection, education, psychosocial and legal aid. Child protection and psychosocial support services are integrated in all other services provided to the OVC.

ANNEX 2: CSF PERFORMANCE MANAGEMENT PLAN INDICATOR TRACKER (JULY 2011-JUNE 2012)

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
CSF GOAL: To ensure that civil society provision of OVC and HIV/AIDS prevention, care, treatment and support services are harmonized, streamlined and effectively contribute to the attainment of GoU NSP, NSPPI and other relevant national plans and policies																
1.	Percentage of service delivery targets met by CSF	Service delivery targets include annual targets for the various services funded by the CSF: OVC, HIV prevention, HCT, PMTCT, palliative care. **Numerator:** number of people who received at least one CSF service and **Denominator:** CSF target group (youth, couples, MARPS) **Unit of measure: % people reached**	Service, Sex	CSF database, CSF quarterly and annual reports	MEA	2008	OVC=0% HIV Prev =0% HCT=0% PC=0%	NA	90% 71% N/A N/A	95% 80% 85% 90%	97% 82% 76% 79%	95% 85% 90% 95%	121% 87.1% 32% 157%	95% 85% 90% 95%	106.39% 204.91% 159.73% 133.9%	Overall FY12 service delivery targets were achieved. The 20% achievement above the target for HCT is attributable to the reduced stock outs of test kits and targeting of densely populated areas while the increase in HIV care is due to increased enrollment of new PLHIV onto care especially in the last half of FY12
2.	HIV Prevalence	Proportion of people with HIV at a given point in time per base population Numerator: Number of people testing positive nationally in a year **Denominator:** Total number of people tested annually **Unit of measure: % of people testing positive**	Sex	UDHS and Sero-behavioral survey 2011 HIV/AIDS Epidemiological Surveillance Report 2010 AIDS indicator survey 5 yearly reports,	MEA	2004	6.2%	n/a	6.4%	n/a	6.4%	n/a	6.3%	n/a	6.7%	HIV prevalence is highest among women at 7.7% compared to 5.6% among the men
KRA 1: CSF MANAGEMENT STRENGTHENED																
3.	Dollar amount of funds raised and managed through the CSF annually	These include funds commitments to sub grantees only **Unit of Measure:** USD	n/a	FMA financial records	FMA	2008	11m	11m	18m	22m	22.09m	23m	20.06m	25m	20.1m	This includes only funds received from ADPs and was committed to the NNGO, HIV1, OVC1 and

[1] Baseline years vary from 2004 to 2010 depending on source of information, time of contracting of the responsible agent, and when the indicator was agreed upon

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
																OVC2 sub grantees during FY12
Sub Result 1.1: CSF governance systems and structures strengthened to deliver service delivery targets by the end of June 2012																
4.	Number of Steering Committee (SC) meetings held to review CSF performance and make decisions	The Steering Committee (SC) of the CSF is a twelve member committee (donors, sub-grantee representatives) that oversees the performance of the Civil Society Fund. The committee meets regularly (quarterly) to plan, review and make program decisions. Unit of measure: # of meetings	n/a	SC minutes	TMA	2009	12	12	12	4	12	4	07	4	15	In FY 12, guidance was given on the solicitation process for RFA 11-001, proposed new CSF log, design of a monitoring tool to track the implementation of the mid-tem review recommendations, approval of ToR for a study to guide the set up of a CSF management structure beyond January 2013
5.	Number of joint outputs/ activities successfully accomplished	The indicator tracks joint outputs/activities that the three management agents produce or work on jointly including: quarterly/annual reports, work plans, capacity building plans, strategic plan, support supervision, proposal reviews, and pre award/post award workshops **Unit of measure: # of Joint Outputs**	n/a	CSF program activity reports	MEA	2009	9	6	9	10	09	10	13	10	16	The joint outputs in FY12 included the end of project assessments of OVC1 and OVC2 projects, Quarterly performance review of Q1&Q2, Pre-award assessments and workshops for RFA 11-001, Quarterly planning for Q1,Q2 & Q3, Desk review of NNGO performance, developing proposed CSF Logo and documentary
Sub Result 1.2: At least $31 million of multi-donor resources managed annually while ensuring efficiency, transparency, timeliness, and value for money by June 2012																
6.	Average lead time for contracting	Lead rate here refers to the average time (months) taken to process a solicitation, that is, from the release of an RFA to actual contracting of the selected sub grantees.	Nature (Competitive or Cost Extension	FMA records	FMA	2008	6	6	7	4		4	6	4	6	The CSF SC had to re-seat and review the recommended/ successful applicants

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
		Unit of measure: average time in months														
7.	Average number of days taken to process grantee quarterly disbursements	Processing here refers to receipt and review of sub-grantee accountabilities, addressing of any issues arising, approval of accountabilities and preparation of funds transfer wires. Quarterly disbursements refer to the funds due to each organization quarter by quarter. **Unit of measure:** Average number of days	n/a	FMA records	FMA	2008	0	20	Not tracked	20	35	20	19	14	16.7	Achievement of target affected by delay by a number of sub grantees in responding to raised queries on submitted accountabilities especially in Q3
Sub Result 1.3: CSF's contribution to the national response to HIV/AIDS and OVC measured and disseminated by June 2012																
8.	Existence of a functional CSF M&E system	Functional M&E system here refers to existence and utilization of qualified staff, standardized data collection and reporting tools; and a database. It also consists of data analysis procedures and timelines, data flow plan as well as a DQA plan **Unit of measure: n/a**	n/a	CSF quarterly reports	MEA	2008	0	Tools designed tested & rolled out	Tools rolled out Data base designed	Data analysis & DQA planned	DQA conducted. Analyzed Data	Data analysis & reporting	01	01	01	M&E system is now fully functional with standard indicators, data collection and reporting tools and a functional web based management information system
9.	% of sub-grantees utilizing CSF standardized primary data collection and reporting tools	This indicator measures the proportion of sub-grantees that have adopted and are using the CSF standardized primary data collection tools that include the OVC register, OVC service tracking tool, OVC service providers training register, HIV prevention people reached register, people trained register, and any other tools that may be developed overtime. **Numerator:** Identified number of sub-grantees using these tools at any given time. **Denominator:** Total number of sub-grantees funded by CSF at that given time.	n/a	JSS reports	MEA	2009	0	100%	100%	100%	92.6%	100%	92%	100%	68%	32% had own tools used to capture data and later transcribed on the CSF tool. This introduced transcription errors. Note that this indicator was assessed for only 42 CSOs visited during FY12
10.	% of sub-grantees submitting quality data on a timely basis	Quality of data is determined during the data quality assessments and Joint Support supervision (JSS) visits by CSF to the sub-grantees. **Numerator:** Identified number of sub-grantees that submitted quality data to CSF. The data set considered could be quarterly, semi-annual, or annual data. **Denominator:** Total number of CSOs where CSF has conducted DQA assessments or JSS during the exercise.	n/a	JSS reports	MEA	2009	33%	50%	55%	75%	59.1%	100%	45.8%	100%	66%	There was notable improvement compared to FY11 is attributable to sub-grantees putting in place DQ control procedures with 72.5% reporting data verification at the various stages of data collection and aggregation.

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
Sub Result 1.4: CSF-generated data utilized in order to improve HIV/AIDS and OVC programming at all levels by June 2012																
11.	Percentage of sub grantees making program implementation decisions based on analyzed data	The indicator measures the number of sub-grantees that make informed management decisions based on analyzed programmatic data. Achievement of this indicator implies that the data is analyzed and used to make decisions. **Numerator:** CSF sub grantees who made program decisions based on analyzed data, **Denominator:** all CSF sub grantees **Unit of measure:** % of sub-grantees	Type of CSO (NNGO, District based NGO /CBO)	CSO program reports	MEA	2009	24.3%	50%	64%	70%	64.18%	80%	54.4%	80%	57.5%	All sub-grantees used data for reporting though only 57.5% conducted further analysis to enable them use data in programming
KRA 2: INSTITUTIONAL/TECHNICAL CAPACITY OF SUB GRANTEES STRENGTHENED																
12.	Percentage of CSF sub-grantees showing increased capacity to collect, analyze, report and use data	Proportion of sub-grantees demonstrating increased capacity in performing data management functions (collect, analyze, report and use).This is a composite indicator that measures all the capacity components of the result above. The various elements of capacity under each component (collection, reporting, and data use) will be determined in the assessment tool that was developed for the baseline M&E capacity assessment. An appropriate sample of indicators will be assessed across all grantees. **Numerator:** CSF sub-grantees demonstrating increased capacity for these M&E elements; **Denominator:** All CSF sub-grantees. **Unit of measure:** % of sub-grantees	Program area (HIV prevention BCC, HCT, PMTCT, HIV Care, OVC)	MEA records/ capacity Assessment reports	MEA	2009	23.4%	50%	54%	60%	54%	70%	71.3%	80%	-	
13.	Percentage of CSF funded sub grantees yielding unqualified audit opinion annually	The unqualified audit opinion has no reservations concerning the financial statements. This is also known as a clean opinion meaning that the financial statements appear to be presented fairly in accordance to the generally accepted accounting principles. **Numerator:** Sub-grantees attaining an unqualified audit opinion; **Denominator:** All CSF funded sub-grantees. **Unit of Measure**: % of sub-grantees	RFA	Audit reports	FMA	2009	70%	n/a	70%	80%	70%	90%	87%	90%	89%	
Sub Result 2.1: Financial management capacity of sub grantees strengthened by June 2012																
14.	Percentage of sub-	This indicator measures proportion of sub	Program	FMA records	FMA	2008	0%	100%	92%	100%	100%	100%	72%	100%	87%	

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
	grantees using CSF financial reporting tools correctly	grantees that adopt and correctly use the harmonized financial reporting format designed by FMA. **Numerator:** Sub-grantees using CSF financial reporting tools correctly; **Denominator:** all CSF sub-grantees. **Unit of measure:** % of sub-grantees	area (HIV prevention BCC, HCT, HIV Care, OVC)													Refer to comment on indicator 15
15.	Percentage of sub-grantees achieving an average monthly burn rate of 70% computed and reported quarterly	The funds burn rate refers to the level of utilization of the released funds by a given sub grantee on planned activities in a given period. **Numerator**: Funds used in a given quarter (computed into monthly averages); **Denominator**: Total funds received from FMA for that quarter computed into monthly averages and reported quarterly. **Unit of measure:** % of sub-grantees	n/a	FMA records	FMA	2008	80%	100%	90%	100%	100%	100%	92%	100%	81%	Performance for FY12 was affected by Q3 performance where only 68% of the funded sub grantees had reported at the time of this reporting
16.	Percentage of sub-grantees complying with financial regulations.	Sub-grantees fully complying with the financial regulations as stipulated in the CSF financial and account manual **Numerator:** Number of compliant sub-grantees **Denominator:** Total number of sub-grantees receiving financial support through the CSF **Unit of measure: % of sub-grantees**	Program area (HIV prevention BCC, HCT, HIV Care, OVC)	FMA Records/ CSO records	FMA	2008	50%	80%	65%	90%	68%	100%	84%	100%	76.3%	Ref Indicator 15
Sub Result 2.2: Technical ad institutional capacity of sub grantees to deliver quality services strengthened by June 2012																
17.	Proportion of sub grantees who demonstrate a 15% improvement on the CSF OCAT score annually	The CSF sub grantees under the different CSF capacity building models will be assessed annually on the 10 capacity elements that is, Aspirations; Strategy; Governance; Leadership and Management; Programme design implementation, monitoring and evaluation; Human Resources; Finance; Infrastructure; External relationships and partnerships and Culture. **Numerator:** Number of sub grantees who demonstrate a 15% improvement on the CSF OCAT Score **Denominator**: All CSF Sub grantees **Unit of measure:** proportion of CSF Sub grantees	Program area (HIV prevention BCC, HCT, PMTCT, HIV Care, OVC	Annual Organizational Capacity Assessment Tool report	TMA	2011							The Mean Score on OCAT was 161	80%	-	Indicator to be assessed in July 2012 (Q1 of FY13)
18.	Percentage of sub-grantees that have mainstreamed gender in their	Gender mainstreaming is the process of assessing the implications for women and men of sub-grantee actions and programs. It is aimed at ensuring that both women and men	Program area (HIV prevention BCC, HCT,	CSO reports/ CSF reports	TMA	2008	0%			54%	-	100%	100%	100%	100%	Following the gender trainings in Q2 and Q3, all sub grantees revised their work

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
	programs	benefit equally and inequality is not perpetuated. **Numerator:** Number of sub-grantees mainstreaming gender in their programs; **Denominator:** All CSF sub-grantees. **Unit of measure:** % of sub-grantees	PMTCT, HIV Care, OVC)													plans to include gender sensitive activities and incorporate tracking of gender sensitive indicators
RESULT 3: SERVICE DELIVERY IN THE NSP/NSPPI PROGRAM PRIORITY AREAS INCREASED																
19.	Proportion of individuals utilizing CSF supported services.	This indicator focuses on the proportion of individuals receiving at least one service under CSF's thematic areas, that is, HIV prevention (BCC), HCT, HIV care and treatment and OVC **Numerator:** Total number of people who utilize CSF services: HIV prevention (BCC), HCT, HIV care and treatment and OVC **Denominator:** Target population in CSF's targeted geographical areas. **Unit of measure:** Proportion of individuals	Sex, Age	CSF data base and (UBOS census reports for population estimates)	MEA	2011	50%	-	-	-	-	56.2%	50%	54.5%	46.8%	
20.	Number of individuals utilizing CSF supported services.	This indicator focuses on the number of individuals receiving at least one service under CSF's thematic areas, that is, HIV prevention (BCC), HCT, HIV care and treatment and OVC **Numerator:** Total number of people who utilize CSF services: HIV prevention (BCC), HCT, HIV care and treatment and OVC **Unit of measure:** # of individuals	Sex, Age	CSF database	MEA	2009	HIV Prev – 183,767 HCT- 154,257 HIV care – 93,287 OVC – 13,204	707,678 - 21,207 45,000	620,678 154,257 93,287 13,204	775,848 169,682 46,400 55,000	638,513 129,740 36,672 53,260	853,433 718,846 30,000 75,000	743,287 232,288 47,075 90,674	825,161 300,000 50,000 75,000	1,690,872 479,209 66,946 79,795	Please refer to indicator specific comments under indicator No. 23, 26, 31 and 33
Sub-Result 3.1 Access to and utilization of HIV/AIDS prevention services increased																
21.	Percentage of individuals who both correctly identify at least two ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	**Numerator:** Number of individuals who both correctly identify at least two ways of preventing the sexual transmission of HIV and reject all major misconceptions about HIV transmission **Denominator:** Number of individuals in the survey. The ways of preventing sexual transmission of HIV include: 1) Abstinence, 2) Being faithful and 3) condom use. The major misconceptions about HIV transmission include: 1) Mosquito bite, 2) Touching an infected person, 3) Sharing food with an infected person, 4) sharing utensils with an infected person and 5) sharing toilets	Sex, Age	LQAS , AIDS Indicator Survey	MEA	2012	28.9%	-	-	-	-	-	-	38%	28.9%	Note that this indicator was adopted in 2012 in Q1 and thus shall be measured to assess change at the beginning of FY13. Thus performance presented is as per the baseline value

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
		with an infected person. **Unit of measure:** percentage of individuals														
22.	Percentage of individuals who had sexual intercourse with a non marital or non cohabiting sexual partner in last 12 months and used a condom at last higher risk sex	**Numerator:** Number of individuals who had sexual intercourse with a non marital or non cohabiting sexual partner in last 12 months and used a condom at last high risk sex. **Denominator**: Number of individuals who had sexual intercourse with a non marital or non cohabiting sexual partner in last 12 months. Higher risk sex is defined as sex with non-marital, non cohabiting partner. **Unit of measure**: percentage of individuals	Sex, Age	LQAS , AIDS Indicator Survey	MEA	2012	72.18%	-	-	-	-	-	-	77%	72.18%	Refer to comment under indicator 21
23.	Number of individuals reached with social and behavioral change communication interventions on HIV/AIDS	Total number of individuals reached with BCC messages given in individual or small groups (less than 25) settings: abstinence, be faithful, condom use, HCT, PMTCT, and other prevention messages. People reached **Unit of measure:** # of individuals	Sex, Age	CSF database	MEA	2009	183,767	707,678	620,678	775,848	638,513	853,433	743,287	825,161	1,690,872	Despite performance for FY12 being lower that that if FY11, achievement remains in tandem with the target at 86% with 3 quarters of FY12 considered. Q3 in particular saw a 45% performance above target owing to improved performance by some NNGOs that were still implementing start-up activities in Q2 and increased use of small group strategy
24.	Number of CSF supported condom outlets	This indicator refers to a count of condom distribution points facilitated by CSF CSOs. Service outlets include facility based like health units/clinic and community based **Unit of measure:** # of service outlets	n/a	CSF database/ CSO reports	MEA	2009	9,068		13,247	15,000	19,062	20,000	22,229	3,500	2,314	While number of service outlets reduced compared to FY11, there was notable increase in number of condoms distributed by the same service outlets
25.	Number of condoms distributed by CSF sub grantees	This indicator refers to a count of condoms distributed through CSF facilitated distribution points. Please note that CSF does not procure condoms but rather facilitates their distribution.	n/a	CSF database/ CSO reports	MEA	2009	4,588,408	6.5m	6,713,719	8m	11,648,254	10m	8,118,849	14,000,000	10,582,726	The slight drop in performance of this indicator compared to FY11 is attributable to condom stock outs in

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
		Unit of measure: # of condoms														Q1 and Q3 of FY12 experienced in districts of focus
26.	Number of individuals who were counseled and received an HIV test in last 12 months and know their results	Individuals who were counseled and tested in last 12 months and know their results. (and received results) Unit of measure: Number of individuals	Sex, age	CSF data base	MEA	2009	154,257		154,257	210,000	169,682	718,846	232,288	300,000	479,209	FY12 presents a 10.4% performance over and above the target. This is attributable to the over 90% performance above the target in Q3 due to increased targeting of densely populated areas by NNGOs, procurement of buffer stocks, incorporation of HCT in BCC small group interventions and reduced stock outs at health facilities in target areas
27.	Percentage of individuals who know two or more benefits of HCT	Numerator: Number of individuals who know two or more benefits of HCT Denominator: Number of individuals in the survey The benefits of HCT includes: 1) Plan future, 2)Avoid infection, 3) Protect unborn child, 4) Go for ART, 5) Learn to live positively Unit of measure: Percentage of individuals	Sex, Age	LQAS reports	MEA	2012	66.9%	-	-	-	-	--	-	77%	66.9%	Note that this indicator was adopted in 2012 in Q1 and thus shall be measured to assess change at the beginning of FY13. Thus performance presented is as per the baseline value
28.	Percentage of individuals who tested for HIV and received their results and disclosed to partners/spouses in the last 12 months	**Numerator:** Number of people who receive HIV counseling, Testing and received results and report disclosing to their partners. **Denominator:** Total numbers of people tested for HCT, know their results, and are participating in the survey. **Unit of measure:** Percentage of individuals	Sex, Age	LQAS Reports	MEA	2012	77.2%	-	-	-	-	--	-	85%	77.2%	- do –
Sub Result 3.2: Access and utilization of HIV/AIDS care and support services in targeted communities increased through CSF sub-grantees by June 2012																
29.	Proportion of PHA receiving a minimum of one clinical service in the last 12 months	**Numerator:** Number of HIV positive adults and children receiving facility, community or home based assessment of need for interventions, alleviation of HIV-related symptoms and pain, and nutritional rehabilitation for malnourished	Sex, Age	CSF data base and the AIS	MEA	2011	46%	-	-	-	-	29%	46%	49%	66%	The improved performance for FY12 as compared to FY11 is attributable to the enrollment of new

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
		PHA **Denominator:** All individuals testing positive in the target population. **Unit of measure:** Proportion of PHA														PLHIV into care by 2 NNGOs in the last half of FY12
30.	Percentage of individuals who know at least two signs or symptoms of TB	**Numerator:** Number of individuals who know at least two signs or symptoms of TB. **Denominator:** Number of individuals in the survey. TB signs and Symptoms include: 1) Cough for two weeks or more, 2) Pain in the chest, 3) Coughing blood/Sputum, 4) Weight loss, 5) Loss of appetite, 6) Evening fever, 7) Sweating at night. Note: Cough must be mentioned. **Unit of measure:** Percentage of individuals	Sex, Age	LQAS Reports	MEA	2012	50.03%	-	-	-	-	-	-	65%	50.03%	Note that this indicator was adopted in 2012 in Q1 and thus shall be measured to assess change at the beginning of FY13. Thus performance presented is as per the baseline value
31.	Number of HIV positive individuals receiving HIV care	Total number of people who are HIV positive that receive facility, community or home based assessment of need for interventions, alleviation of HIV-related symptoms and pain, and nutritional rehabilitation for malnourished PHA **Unit of measure:** # of HIV positive individuals	Sex, Age	CSF database/ CSO reports	MEA	2009	93,287	21,207	93,287	46,400	36,672	30,000	47,075	50,000	66,946	The 34% Performance of FY12 over and above the target is attributable to increased enrollment of PLHIV onto care by two care NNGO sub grantees
Sub Result 3.3: Access and utilization of OVC services increased among OVC and their households as outlined in the NSPPI by June 2012																
32.	Percentage of OVC receiving a comprehensive package of services	Comprehensive package refers to an OVC receiving at least a service in three or more core programme areas of the NSPPI **Numerator:** Number of OVC receiving a comprehensive package **Denominator:** Total number of OVC receiving external support **Unit of measure:** % of OVC	Sex, Age	CSF database and LQAS reports	MEA	2011	-	-	-	-	-	100%	51%	100%	54.84%	Performance against target affected by scale down of interventions in Q3 by OVC sub grantees
33.	Number of OVC receiving at least one service in any core programme area beyond PSS	Number of eligible orphans and vulnerable children aged 17 years and below provided with at least a service in a CPA beyond. **Unit of measure:** # of OVC	Sex	CSF database/ CSO reports	MEA	2009	13,204	45,000	13,204	55,000	53,260	75,000	90,674	75,000	79,795	Performance dropped by 21% compared to FY11 due to scale down of interventions in Q3 of FY12 by OVC1 and OVC2 sub grantees as CSF funded projects were closing
34.	Percentage of OVC 5-17 experiencing cases of child abuse	There is no evidence of abuse or neglect, child does not carry out inappropriate labour/work, child is not being exploited in any other way.	Sex, Age	LQAS	MEA	2012	32.51%	-	-	-	-	-	-	20%	32.51%	Note that this indicator was adopted in 2012 in Q1 and thus shall be

No.	Performance indicator	Indicator Definition	Disaggregated by	Data Source	Lead CSF Agent	Baseline Year[1]	Baseline value	FY 09 Target	FY 09 Actual	FY 10 Target	FY 10 Actual	FY 11 Target	FY 11 Actual	FY 12 Target	FY 12 Actual	Comments
		Numerator: Number of OVC reporting child abuse. **Denominator:** Total number of OVC in the survey. **Unit of measure:** % of OVC														measured to assess change at the beginning of FY13. Thus performance presented is as per the baseline value
35.	Percentage of OVC households that are food secure	By Food Secure, we mean the household at all times has both physical and economic access to sufficient food to meet the dietary needs of all OVC in the house hold for a productive and healthy life. **Numerator:** Number of households with food at all times **Denominator:** Total number of households surveyed **Unit of measure:** % of households	Sex, Age	LQAS	MEA	2012	46.4%	-	-	-	-	-	-	55%	46.4%	Please refer to comment under indicator 34

ANNEX 3: SUMMARY QUARTERLY STATISTICS BY PROGRAM AREA (JULY 2011 -JUNE 2012)

SERVICES PER PROGRAM AREA	Jul - Sep 2011			Oct - Dec 2011			Jan - Mar 2012			Apr - Jun 2012		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
HIV PREVENTION												
Behavior Change Communication (BCC)												
# of people given BCC Messages	**102,331**	**103,959**	**206,290**	104,528	101,989	**206,517**	215,037	213,693	**428,730**	**428,788**	**421,339**	850,127
# of MARPs given BCC messages	25,477	23,049	**48,526**	18,353	15,834	**34,187**	23,736	20,877	**44,613**	25,609	24,194	49,803
MARPs %age			**23.52%**			**16.55%**			**10.41%**			5.86%
Condom programming												
# of condoms distributed to service outlets	1,668,551	364,847	**2,033,398**	2,813,152	150,433	**2,963,585**	2,908,310	281,559	**3,189,869**	2,836,644	375,045	**3,211,689**
Female condom %age			**17.94%**			**5.08%**			**8.83%**			**11.68%**
HIV Counselling and Testing												
# of people counseled &tested for HIV and given results (C,T & R)	41,503	41,175	**82,678**	52,165	52,275	**104,440**	71,057	72,989	**144,046**	72,053	75,992	**148,045**
# of Couples C,T &												

R	9,151	9,151	**18,302**	9,486	9,515	**18,972**	5,358	5,358	**10,716**	4,413	4,413	**8,826**
# of people HIV Positive	1,794	2,232	**4,026**	1,957	2,779	**4,736**	1,951	2,739	**4,690**	1,727	2,225	**3,952**
HIV Sero Prevalance			**4.87%**			**4.53%**			**3.26%**			**2.67%**
Safe Male Circumcission												
# of males medically circumsized	445	-	**445**	334	-	**334**	953	-	**953**	2,405	-	**2,405**
Community PMTCT												
# of pregnant and lactating females mobilized from the community for PMTCT	-	3,342	**3,342**	-	4,192	**4,192**	-	5,219	**5,219**	-	1,140	**1,140**
HIV CARE												
# of PLHA given a minimum one clinical HIV Care service	8,855	19,219	**28,074**	10,887	20,552	**31,439**	16,406	32,290	**48,696**	19,773	28,787	**48,560**
# of PLHA given Cotrimoxazole prophylaxis	7,025	14,273	**21,298**	2,859	6,746	**9,605**	9,577	8,396	**17,973**	14,967	12,210	**27,177**
%age on cotrimoxazole			**75.86%**			**30.55%**			**36.91%**			**55.97%**
OVC												
# of OVC served	39,854	37,673	**77,527**	33,050	32,005	**65,055**	28,930	26,985	**55,915**	1,839	1,583	**3,422**

ANNEX 4: FINANCIAL REPORT

CIVIL SOCIETY FUND
INCOME AND EXPENDITURE STATEMENT
AS AT 30TH JUNE 2012

	Annual results to 30 June 2012 UGX	Cumulative results to 30 June 2012 UGX
Income		
Grant income	47,984,319,704	199,124,064,297
Interest Income	916,820,667	2,138,916,340
Other income	12,045,489,917	26,494,118,716
Total Income	**60,946,630,288**	**227,757,099,353**
Project Expenditure		
National NGOs	(593,719,421)	63,591,258,589
HIV Prevention round 1	6,436,106,994	20,546,487,093
HIV Prevention round 2	1,278,348,526	9,438,522,385
OVC round 1	4,496,006,349	13,063,697,238
OVC - Local Governments	458,994,526	1,772,475,113
Paed aids	1,102,421,988	2,593,702,950
OVC round 2	2,527,610,452	5,345,742,025
TSO	199,738,326	2,630,585,991
NNG02	23,185,345,398	23,185,345,398
	39,090,853,138	**142,167,816,783**
Other expenditure	9,240,447,967	25,681,846,154
Total Expenditure	**48,331,301,105**	**167,849,662,937**
Surplus of Income over Expenditure	**12,615,329,183**	**59,907,436,416**

Represented by:

Project Advances

National NGOs	506,586,580	3,118,121,511
HIV Prevention round 1	(1,801,370,087)	1,166,267,091
HIV Prevention round 2	(1,286,803,912)	8,865,142
OVC round 1	(2,028,846,562)	108,291,013
OVC - Local Governments	(463,704,385)	12,739,052
Paed aids	(1,102,421,988)	11,744
OVC round 2	(1,378,132,390)	110,644,480
TSO	(200,252,226)	(3)
NNG02	(6,787,190,954)	8,903,432,232
	(14,542,135,924)	**13,428,372,262**
Bank Accounts	27,157,465,106	46,479,064,154
	12,615,329,182	**59,907,436,416**